Cornea Revolution
Optimal Cornea Laser Repair & Vision Institute

Patient Information

First Name_____ Middle Initial _____ Last Name _____

Address: _____ Age_____ Sex (circle one): M F X

City: _____ State: _____ Zip_____

Date of Birth: _____ Driver's License # _____

Occupation: _____

Email: _____

Cell Phone: _____

Spouse, Parent, or Legal Guardian Information

Spouse, Parent, or Legal Guardian*: _____ Phone: _____

Address (if different from patient) _____

Emergency Contact (if different from above*): _____Relationship: _____
Phone: _____

Referred here by: _____ Medical Doctor: _____

Other Doctors treating you: _____

Medical Insurance: _____Member I.D. & Group #_____/_____

Primary Pharmacy: _____ Address: _____

Do you wear Eyeglasses or Contact Lenses? If yes, Eye glasses how long? _____ If yes, Contact lenses how long? _____ Type of Contact lens (circle one): Soft / Hybrid / RGP / Scleral / Other: _____

Medical/Surgical History (of the eye): _____

_____

Medical History: _____

_____

Previous Eye Surgery: _____ If so, what year_____ By Doctor: _____

List any Medications you take: _____

Allergies to Medications: _____